Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2300AGC	A. BUILDING _____ B. WING _____	C 01/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HOME CARE OF NV	3856 JEWEL AVE. LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on 01/27/09. The facility was licensed as a six (6) beds Residential Facility for Groups which provides care to elderly and disabled persons, Category II residents. The census was four (4) residents. Three (3) of four (4) resident files were reviewed. One (1) discharged resident file was reviewed. One (1) of two (2) employee files were reviewed. There was one (1) complaint investigated. Complaint # NV20324 was substantiated. (See ACTS) The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	Y 000	Acceptable POC 3/6/09 Dell W Sampson RECEIVED MAR 0 5 2009 BUREAU OF LICENSURE AND CERTIFICATION LAS VEGAS, NEVADA	
Y 682 SS=D	449.271(3) Prohibited Condition / Serious medical condit NAC 449.271 Except as otherwise provided in NAC 449.2736, a person must not be admitted to a residential	Y 682		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ASST Administrator — (X6) DATE: 3/3/09

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2300AGC	A. BUILDING _____ B. WING _____	C 01/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HOME CARE OF NV	3856 JEWEL AVE. LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 682	Continued From page 1 facility or permitted to remain as a resident of a residential facility if he: 3. Suffers from any other serious medical condition that is not described in NAC 449.2712 to 449.2734, inclusive. This Regulation is not met as evidenced by: Based on record review and staff interview on 1/27/09 the facility failed to ensure 1 of 4 residents be admitted or permitted to remain had a condition or equipment requiring the management of a trained medical professional (#4). Findings include: Review of Resident #4's, admit date 12/11/08, file revealed a chest X-Ray result on 12/10/08 with a peripherally inserted central catheter (PICC) line inserted on the left side near the superior vena cava and right atrium. Interview with Employee #2 on 1/27/09 at 3:10 PM indicated Resident #4 was admitted to the facility with a PICC line and a catheter. Severity: 2 Scope: 1	Y 682	TAG Y 682 A) Picc line of Resident was not Witnessed until After resident was at the facility for a time. B) ASST ADministrator will review all residents for compliance upon entering the facility. C) 3/1/09	
Y 830 SS=D	WAIVERS 1. The administrator of a residential facility may submit to the Division a written request for permission to admit or retain a resident who is prohibited from being admitted to a residential facility or remaining as a resident of the facility	Y 830		

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2300AGC	A. BUILDING _____ B. WING _____	C 01/27/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
UNIVERSAL HOME CARE OF NV	3856 JEWEL AVE. LAS VEGAS, NV 89121

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 830	Continued From page 2 pursuant to NAC 449.271 to 449.2734 , inclusive. This Regulation is not met as evidenced by: Based on record review, the Administrator failed to apply for a hospice waiver for 1 of 4 residents receiving hospice care (#4). Findings include: A review of Resident #4's, date of admission 12/11/08, file revealed the facility lacked documented evidence of a hospice waiver. Resident #4's file contained evidence of a hospice admission on 12/22/08. Employee #2 on 1/27/09 at 3:10 PM stated "we were going to apply for a hospice waiver, but he (Resident #4) died on New Years day" Severity: 2 Scope: 1	Y 830	TAG Y830 A) UHC Will Keep Hospice Waiver forms on hand in the event of future Compliance. B) In the event of future possibilities, UHC Will apply for Hospice waiver upon talk of Putting Client (of Approval) on such Program C) 3/3/09	